

Case Number:	CM15-0009997		
Date Assigned:	01/27/2015	Date of Injury:	06/18/2003
Decision Date:	03/19/2015	UR Denial Date:	12/17/2014
Priority:	Standard	Application Received:	01/16/2015

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Texas, New York, California
 Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 64 year old male sustained an industrial injury on 6/18/03, with subsequent ongoing low back and right shoulder pain. Treatment included chiropractic therapy, physical therapy, epidural steroid injections, right shoulder rotator cuff repair and medications. In a progress note dated 12/11/14, the injured worker complained of constant low back and right shoulder pain 7-8/10 on the visual analog scale associated with leg numbness. The injured worker reported going to the Emergency Department on 12/1/14 due to pain in the back, right shoulder and leg. X-ray of the right shoulder showed calcific tendinitis of the right shoulder but no dislocations or fractures. Current diagnoses included displacement lumbar intervertebral disc without myelopathy, right rotator cuff tear, long term use of other medications and tear medial cartilage or meniscus knee. Physical exam was remarkable for an antalgic gait. The physical exam did not include a shoulder assessment. A request for authorization was submitted on 12/11/14 for left shoulder magnetic resonance imaging. On 12/17/14, Utilization Review noncertified a request for MRI of the right shoulder with contrast and modified a request for Norco 10/325mg #90 to Norco 10/325mg #51 citing CA MTUS Chronic Pain Medical Treatment Guidelines. As a result of the UR denial, an IMR was filed with the Division of Workers Comp.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

MRI of the right shoulder with contrast: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 214.

Decision rationale: Yes, the proposed MRI of the right shoulder is medically necessary, medically appropriate, and indicated here. As noted in the MTUS Guideline in ACOEM Chapter 9, Table 9-6, page 214, MRI imaging is recommended in the preoperative evaluation of full-thickness and/or partial-thickness rotator cuff tears. Here, the requesting provider suggested that the applicant had a history of prior shoulder surgery, had a presentation suggestive of a recurrent rotator cuff tear, with signs including limited range of motion and positive provocative testing about the same, was in the process of re-consulting his shoulder surgeon and was, by implication, seemingly intent on pursuing a surgical remedy based on the outcome of the same. Therefore, the request was/is medically necessary.

Norco 10/325mg #90: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 7) When to Continue Opioids Page(s): Chronic Pain Medical Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page 80 of 127.

Decision rationale: Conversely, the request for Norco, a short-acting opioid, was not medically necessary, medically appropriate, or indicated here. As noted on page 80 of the MTUS Chronic Pain Medical Treatment Guidelines, the cardinal criteria for continuation of opioid therapy include evidence of successful return to work, improved functioning, and/or reduced pain achieved as a result of the same. Here, however, the applicant was/is off of work, it was acknowledged on several occasions, referenced above. The applicant was using a walker to move about. The applicant was severely obese, with the BMI over 50. The applicant was substantially inactive, it was implied. The attending provider's progress notes failed to outline any quantifiable decrements in pain or material improvements in function effected as a result of ongoing Norco usage. Therefore, the request was not medically necessary.